Dear Patient:

Thank you for choosing Northwestern Medical Center for your health care needs. If payment of your medical bills would create a financial hardship for you, we will work with you to apply for financial assistance. All other potential payment sources will need to be explored first, such as insurance, Government programs, etc. We may require that you apply for Medicaid.

Please answer all questions on the application completely—indicate "zero" or "does not apply" where appropriate. Applications that are incomplete or do not have appropriate proof of income will be returned requesting additional information.
The following proof of income is requested:

- Most recently completed federal tax return
- Copies of Social Security checks or documentation from Social Security of your benefits
- A bank statement showing direct deposits of retirement or Social Security benefits.
- Proof of Child Support paid or received

We will notify you of our decision within 15 days of receipt of a complete application. If you have any further questions regarding this process, please contact us at (802) 524-1048.

***All personal information submitted will be held in strictest confidence.**

Sincerely,

Customer Service
802-524-1048

133 Fairfield Street
Saint Albans, VT 05478

NMC: 802-524-5911
Toll Free in VT:
800-696-0321

NORTHWESTERN MEDICAL CENTER
REQUEST FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

Name _____

Mailing Address _____

Daytime Phone _____

GUARANTOR/SPOUSE

Name _____

Mailing Address (if different than above) _____

Daytime Phone _____

Employer _____

Social Security Number _____

NAME AND AGES OF PEOPLE PATIENT/GUARANTOR/SPOUSE ARE FINANCIALLY RESPONSIBLE FOR:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

PLEASE COMPLETE THE ATTACHED FINANCIAL DISCLOSURE WORKSHEETS AND ENCLOSE THE SUPPORTING DOCUMENTATION DESCRIBED IN THE ATTACHED LETTER

I affirm that all information provided on this application is accurate to the best of my knowledge. I authorize Northwestern Medical Center to verify employment, and all financial information provided herein to determine eligibility for financial assistance.

Signature of Patient or Guarantor _____

Print Name of Person Completing this Application _____

Date _____

Attn: Customer Services
Northwestern Medical Center
133 Fairfield Street
Saint Albans, VT 05478

MONTHLY HOUSEHOLD NET INCOME

Income

Gross salaries/wages/tips	$ _____
Social security payments received	_____
Pension or retirement payments received	_____
Interest income	_____
Dividend income	_____
Unemployment/workers' compensation payments received	_____
Rental income	_____
Child support/alimony payments received	_____
Other (describe):	
_____	_____
_____	_____
Total Monthly Income	$ _____

Expenses

Mortgage/rent	$ _____
Property taxes	_____
Auto loans	_____
Credit card payments	_____
Utilities	_____
Child support/alimony	_____
Insurance--auto, home, health	_____
Medical expenses	_____
Other living expenses--telephone, heat,food,gas,water,sewer,rubbish	_____
Other (describe):	
_____	_____
_____	_____
Total Monthly Expenses	$ _____

TOTAL MONTHLY HOUSEHOLD NET INCOME
(monthly income minus monthly expenses) $ _____

PATIENT NAME _____

NET WORTH

Assets

Balance in checking accounts	$ _____
Balance in savings accounts	_____
CDs	_____
Stocks	_____
IRAs, 401ks, and other retirement funds	_____
Market value of real estate (other than primary residence)	_____
Market value of autos	_____
Other assets (describe):	
_____	_____
_____	_____
_____	_____
Total Assets	$ _____

Liabilities

Outstanding balance on credit cards	$ _____
Outstanding balance on auto loans	_____
Outstanding balance on real estate loans (excluding primary residence)	_____
Other debt (describe):	
_____	_____
_____	_____
_____	_____
Total Liabilities	$ _____
NET WORTH (total assets minus total liabilities)	$ _____